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Editorial

Health, population and development

Dr Hiroshi Nakajima, Director-General of the World Health Organization

In 1984, when the Second International Conference on Population was held in Mexico, the world population was about 4800 million. Now, ten years later, on the eve of the International Conference on Population and Development in Cairo, it is about 5700 million. What sort of life can the newcomers, these 900 million infants and children of today, expect when they are young adults in 2015, the target-year for the health goals to be set by the Cairo Conference? And what changes will be required from health services to meet their needs?

Over the past 50 years, global economic growth has generally made the developed countries more affluent and better equipped with health care. The least developed countries, however, have been excluded from these benefits and, as a result, their health infrastructure has remained inadequate.

Some 80% of the world's under-25-year-olds now live in developing countries. This figure is estimated to rise to 86% by the year 2000. As young people enter puberty, they face specific health risks and concerns. Unsafe sexual behaviour can result in unwanted pregnancies, unsafe abortions and sexually transmitted diseases, including HIV infection and AIDS. Health programmes must promote and protect adolescents' health, in particular by fostering healthy behaviour and lifestyles.

WHO estimates that the global population aged 65 years and over is increasing by nearly 800 000 a month. Thus, between 1990 and 2015, their total number will grow from over 300 million to over 540 million. As older people are at greater risk of chronic disabilities, health services will need to be adjusted to meet a larger and heavier demand.

The family, as the basic unit, must be at the core of all strategies for health, population and development. Its stability must be supported and enhanced, especially through public health policies. Family planning programmes should focus on empowering women to manage their own fertility while emphasizing men's joint responsibility in sexual and reproductive health. Universal access to a wide range of safe, affordable and effective family planning choices would probably bring more benefits to more people at a lower cost than any other single technology currently available.

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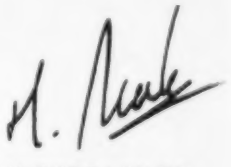
A majority of developing countries have made marked progress in implementing population policies and programmes, and several have been highly successful in slowing down population growth. Political commitment has proved to be one of the most important factors influencing the effectiveness and success of any population programme.

On all these fronts, WHO has a crucial role to play. It must work with governments and urge them to provide adequate health systems and adapt them to the changing needs of individuals and communities. It must support Member States in their efforts to translate into action their commitment to primary health care. One of the keys to attaining our common goal of health for all is for couples to ensure that every birth that occurs does so because it is truly wanted. Another is for all people to participate individually and as members of the community in ensuring their own health development, in a spirit of mutual responsibility, equity and social justice. ■



Hiroshi Nakajima, M.D., Ph.D.

Family planning and the role of WHO

Alexander Kessler

The success of family planning programmes has led to a considerable decrease in average family size in developing countries, yet actual numbers continue to increase. This poses enormous challenges in terms of providing food, water, energy and services, let alone improving the quality of life. Far more emphasis must be placed on the importance of family planning services.

The last 30 years have witnessed one of the great social revolutions of all times: the realization by governments of the need for family planning programmes to allow people to control their own fertility. As a result, 51% of couples in developing countries are now using fertility regulating methods as against only 9% in the 1960s. Yet the world's population continues to grow rapidly. In 1960 there were 3000 million people and in 1990, 5300 million. The actual number of women in developing countries not using any form of contraception remains virtually unchanged: 350 million in 1960, 326 million in 1990.

Thus the challenge to expand family planning coverage is all the greater: not only is it necessary to reach those couples who have never practised contraception while wanting to, but these programmes in developing countries would need to recruit about 100 million more contraceptive users in the year 2000 than in 1990 just to keep pace with population growth.

But if the world population in the year 2000 is not to exceed the median UN projection of 6300 million, the rate of use of contraception will have to rise from the current 51% to 59%: this will mean providing these methods to an additional 86 million couples. Global figures tend to hide the wide variations in access to these services in the developing countries. In East Asia, 95% of couples have good access; the proportion drops to about 55% in South and South-East Asia and Latin America, around 20% in North Africa and West Asia, and less than 10% in sub-Saharan Africa.

Family planning clinic in Barbados. Around half of the couples in developing countries are using fertility regulation methods.

Even countrywide figures mask great differences in availability, for example between urban and rural areas, and between the wealthier and poorer sections of the community. Certain groups in the population tend to be underserved: unmarried women, men, migrants and refugees. Teenagers have, in recent years, become increasingly sexually active, yet in very few countries are their needs met for information about sexuality and contraceptives, let alone for services.

Illegal abortions

Failure to provide adequate family planning services results in women resorting to clandestine abortion when faced with an unwanted pregnancy. At least 12 million illegal abortions occur each year in developing countries. These lead to about 200 000 maternal deaths and a

There are still more than 300 million women in the developing countries who do not use any form of contraception

still higher toll in morbidity; in Africa, for example, the majority of cases treated in gynaecological wards are women with complications of abortion, while 50% of maternal deaths in Nigeria are due to clandestine abortion.

Beyond the challenge of expanding coverage lies that of improving the quality of the services. All matters relating to sex and reproduction are sensitive, and services need to take this into account at both the personal and cultural level. Too often in the past these considerations have been neglected. Services must also be geared to ensure unbroken continuity of family planning care and of supplies of suitable methods.

Over the past 20 years it has become amply evident that programmes which offer a wide variety of methods are the more successful. These include pills, intrauterine devices, injectables and implants, barrier methods including condoms, abortion and sterilization. This allows choice among and opportunities to switch methods. Some of those now available, although a great improvement on what was at hand a generation ago, still present problems, especially in developing countries. There is a need for additional inexpensive, safe, acceptable and easy-to-deliver birth control methods.

Until recently, most programmes focused principally on providing contraception and much less attention was paid to sex education. The increase in adolescent sexual activity, pregnancy and abortion, and the widespread rise in sexually transmitted diseases (STDs), including AIDS, have convinced those running the programmes that an intrinsic part of their activities should be concerned with promoting healthy and responsible sexuality. Faced with over 350 000 new cases of sexually transmitted infections occurring every day in the world, family planning programmes, reaching as they do an important part of the sexually active population, are being challenged to become more decisively involved in the prevention and control of STDs, including AIDS.

The population dimension

Family planning programmes have led to a considerable decrease in average family size in developing countries: from 6.1 children per woman in the early 1960s to 3.9 today. Yet this is still far higher than the average of 2.1 children per woman at which level the population would stop growing. Actual numbers continue to increase. The population of developing countries has doubled in the same period, reaching 4100 million in 1990. It is predicted to rise to 5000 million by 2000, out of an optimistic forecast of a world total of 6300 million.

This poses enormous challenges in terms of providing the food, water, energy and services required to support such numbers, let alone improve their quality of life. For the health sector, the sheer numbers magnify the burden of disease. More training, facilities and funding will be needed for all services, including family planning.

WHO's role

One of WHO's most important contributions to family planning has been to advocate these services as an integral part of primary health care. A mother's health and that of her children are deeply affected by the timing of her pregnancies and the number of births. Moreover, combining family planning with maternal and child health (MCH) services made it socially acceptable and within reach of an appreciable proportion of the sexually active population.

In the past 20 years, WHO has collaborated with 130 countries on MCH family planning service projects. Funds were mainly made available by the United Nations Population Fund (UNFPA), amount-

A family in Jamaica. Access to contraception varies widely from country to country

ing to over US$ 300 million. At the same time WHO has worked out broadly applicable approaches that can be readily adapted to different countries' needs. Guidelines and manuals deal with such issues as the mix of methods to be offered in family planning clinics, and the training of midwives and community involvement and self-reliance in these fields.

Owing to pressure of work in busy MCH clinics, family planning is sometimes neglected. More resources and more emphasis on its importance should improve the situation. The combined approach may also neglect the needs of certain sections of the population: couples who wish to delay the birth of their first child, men, adolescents, single women. It needs to be complemented through the involvement of other health and community channels. WHO has an important role of advocacy and coordination to play in this respect.

Family planning also means ensuring that all pregnancies are wanted.

WHO's other major effort in relation to family planning has been to set up a global programme of research and development. It aims to develop new fertility regulating methods suitable for use in developing countries, and to assess the safety and effectiveness of currently available methods. It also studies the behavioural and social determinants, and investigates new approaches to the delivery of family planning care. Some 1200 institutions in 97 countries have collaborated in these activities during the past 20 years. Voluntary contributions to this programme of over US$ 300 million have been made available mainly by governments, but also by a few agencies such as UNFPA and the World Bank.

As for the population dimension, WHO does not, as a matter of principle, advocate any particular population policy; it leaves such decisions to individual governments. But it does provide its Member States with demographic data and health statistics of vital importance to the formulation of health policies and to the planning of health services. It could do still more by translating these data into forecasts of the future burden of disease and the likely demand on health services. More generally, it could speak out more forcefully on the realities of population growth and its implications for health and the health sector. ■

Population policies are the responsibility of governments. WHO provides them with demographic data and health statistics.

Dr Alexander Kessler was Director of the WHO Special Programme of Research, Development and Research Training in Human Reproduction (HRP) from its inception until 1984. His address is 4 Ellerdale Close, London NW3 6BE, England.

Science academies call for action on population

Leila Mehra

The world is in the midst of an unprecedented expansion of human numbers. It took hundreds of thousands of years for our species to reach a population level of 10 million, only 10 000 years ago. This number grew to 100 million about 2000 years ago and to 2500 million by 1950. Within less than the span of a single lifetime, it has more than doubled to 5500 million in 1993.

In view of this alarming situation, an urgent call was made by the representatives of the national academies of science throughout the world at an unprecedented "Science Summit" on World Population in New Delhi, India, on 24-27 October 1993. The participants, in a joint statement, asked for immediate action by governments and decision-makers to adopt an integrated policy on population and sustainable development on a global scale. They hoped that the Statement would reach the attention of governments and peoples of all countries and contribute to further discourse and appropriate policy decisions on these complex but critically important matters, and provide scientific input into preparations for the International Conference on Population and Development.

The Statement declared: "Humanity is approaching a crisis point with respect to the interlocking issues of population, environment, and development. Scientists today have the opportunity and responsibility to mount a concerted effort to confront our human predicament. But science and technology can only provide tools and blueprints for action and social change. It is the governments and international decision-makers, including those meeting in Cairo in September 1994 at the United Nations International Conference on Population and Development, who hold the key to our future.

Bringing health and family planning information to the village.

"We urge them to take incisive action now and to adopt an integrated policy on population and sustainable development on a global scale. With each year's delay the problems become more acute. Let 1994 be remembered as the year when the people of the world decided to act together for the benefit of future generations."

Signed by representatives of 58 academies, the Statement reflects continued concern about the intertwined problems of rapid population growth, wasteful resource consumption, environmental degradation and poverty. The academies believe that ultimate success in dealing with global social, economic and environmental problems cannot be achieved without a stable world population. The Statement underscored the goal of reaching zero population growth within the lifetime of our children.

One of the main conclusions reached was that sustainability of the natural world is everyone's responsibility, including individuals, communities, private institutions, governments, nongovernmental organizations and the international community.

Among the major recommendations are:

- equal opportunities for women and men in sexual, social and economic life so they can make individual choices about family size;
- universal access to convenient family planning and health services, and a wide variety of safe and affordable contraceptive options;
- encouragement of voluntary approaches to family planning, and elimination of unsafe and coercive practices.

The Statement ended by declaring: "Action is needed Now." ■

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Adolescents – the hope for the future

Herbert L. Friedman

A combination of many factors is exerting pressure on young people to engage in sexual intercourse before marriage more than in the past, with important consequences for their psychological, physical and social health and well-being.

Adolescence, the transition between childhood and adulthood, is a formative period of life in all societies. It is a time when patterns of behaviour and relationships begin which will have lifelong effects on the individual, the family and society. Increasing autonomy means that young people begin to have greater choice in what they eat, the kinds of risks they take, whether they use tobacco, alcohol or other drugs, their personal hygiene and – perhaps most central of all to human development – the way they deal with the burgeoning sexuality that is a universal part of adolescent experience in all societies.

Overall population growth depends, to a considerable degree, on the will and behaviour of individual men, women and couples. Adolescence, when procreation first becomes possible, is a crucial time for determining individual fertility patterns which will have major implications for long-term population growth as well as for the survival, health and status, especially of the young mother and her offspring. Unprotected sexual relations in adolescence, with the risk of pregnancy, are also accompanied by risks of sexually transmitted diseases including AIDS to both sexes.

In the last few decades, major changes have taken place which have had an impact on sexual and reproductive health-related behaviour and its consequences among adolescents and youth – those aged between 10 and 24. Over half the world population is below the age of 25, while more than 1500 million are between the ages of 10 and 24, of whom 80% live in developing countries. This trend is increasing; by the year 2000 it is anticipated that 86% of those under 25 will live in developing countries. At the same time the world's great cities are rapidly expanding, especially in developing countries. In 1950, 17% of the population of developing countries lived in urban areas; by the year 2000, it is expected to be 45%. Young people who seek work, or a different lifestyle, move to cities, often into the peri-urban conglomerates which have virtually no health or social welfare infrastructure to help meet their needs.

These changes also mean greater pressure for education, training, jobs and housing in many of the countries which are becoming economically poorer. This puts enormous psychological as well as material stress on young people and their families. Migration also often means the splitting of families. The decline in the size and authority of the family and the exposure to vastly different ways of life in cities, compared to the rural way of life, are among the important factors contributing to behavioural changes in young people.

New patterns of behaviour

The explosion of telecommunications across cultural boundaries and the increase in travel – whether tourism or migration – are also influencing the behaviour of young people by providing models, pressures and greater opportunities for sexual encounters. The family which once offered protection and education of a particular kind in traditional societies is less and less able to do so, as the prevalence of the extended multi-generational family of traditional societies gives way to the nuclear family and, increasingly, to single parent families and the no-parent families of "street children". At the same time there has been little advance in the provision of practical sexual education or in access to contraception, with or without counselling, to adolescents. At the individual level, puberty is generally beginning earlier (except in some industrialized countries where it has reached a plateau) while marriage generally occurs later.

These many factors in combination exert pressure on young people to engage in sexual intercourse before marriage much more than in the past, with important consequences for their own psychological, physical and social health and well-being, as well as for that of children born to them. In addition to the age-old problem of too early marriage and childbearing that still prevails in some societies, new patterns of behaviour are giving rise to new health problems. The increase in both sexes of premarital sexual relations is increasing the health risks of unwanted pregnancy, hazardous induced abortions, sexually transmitted diseases, and infection with the human immunodeficiency virus (HIV) leading to AIDS. These contribute to greater morbidity, mortality and infertility in the young population.

Apart from having unwanted children too early and outside of marriage, many young women are likely to have them too close together, or have more children than they can effectively rear, especially if the father is also young. Those children, in turn, often perpetuate the poverty cycle by becoming parents themselves in their early adolescence. At the same time, in some of the least developed countries which are predominantly rural, early marriage remains the norm, contributing to too early pregnancy and childbirth with consequent mortality and morbidity risks to mother and child, and to relatively unchecked population growth. More than 50 countries permit marriage below 16 with parental consent, while in reality many young people are getting married below the legal permitted age.

Adolescents should be made aware of the risks attached to unprotected sexual relationships.

In many regions, women tend to marry and bear children at too young an age.

We know that the sexual, contraceptive and prophylactic behaviour of young people depends very much on the nature of their relationships. First, with each other, but also with their parents and other significant adults in their families, with schools and with the health services. If these are open, equitable relationships built upon mutual respect, the young person, or young couple, is in the strongest position to take effective action and plan ahead. If, on the other hand, communication is poor between the two sexes, if the girl's status is low, if the boy does not see himself as responsible for his action, and if adults in the community find it difficult to listen, discuss and inform young people in ways that are helpful, the scene is set for unprotected sexual relations – often with disastrous consequences for the individual and long-term damage to the society.

What must be done?

While there has been an overall increase in awareness of the need for better adolescent reproductive health in most countries of the world, major problems remain which need to be overcome. They include:

- lack of sound information and the prevalence of much misinformation among adolescents and those to whom they turn for help;
- non-use of contraceptive and prophylactic measures by adolescents;
- lack of services, including education, counselling and clinical services specifically designed to meet adolescent needs;
- under-use of services which do exist;

- paucity of communication skills and knowledge among those who provide services to adolescents;
- lack of coherent policies to promote sexual and reproductive health across all relevant sectors; and
- reluctance on the part of many governments to implement action which may be controversial in their societies.

A first essential is to provide useful and relevant education on sexual matters to young people within an appropriate cultural context, as well as information about existing services and how to use them. One of the best and simplest ways to start this process is by collecting the sort of questions that young people ask and sharing them with key authority figures, including policy-makers, those who provide education and services, and religious and community leaders. Where this has been done there is immediate recognition that, if those in authority don't help young people, they will not merely remain ignorant but will be dangerously misinformed.

A second essential is to improve services, even in small and not necessarily costly ways such as providing greater privacy or setting aside a special time (and publicizing it) during the week when young people can come for any health need. Youth and other community organizations can play a major role in helping to provide information, and serving as an effective conduit to people in the health sector who wish to help adolescents.

A third essential is the training of service providers, in all sectors, in the skills of interpersonal communication with the young, especially in listening skills, to give them a thorough grounding in adolescent sexuality and the special concerns of the young.

A fourth essential is for policy reviews in each society to help identify, make coherent and enforce laws and policies on such issues as the minimum age of marriage for boys and girls, consent needed for contraception or pregnancy termination services, sexual abuse, child care, compulsory education requirements, and the fate of pregnant adolescents in the educational system. WHO, with support from the UN Population Fund (UNFPA), has developed a series of methods for planning, training, advocacy, research and evaluation which will better promote young people's health, with their active involvement.

Increased access to education also increases young people's responsible attitudes towards sexuality and reproductive life issues.

There are many causes for concern in the world today, but one of the most heartening signs has been our experience of working in all regions of the world with young people in partnerships for health. It has become abundantly clear that when they are given sound information and trust, they are more likely to behave responsibly in the interests of their own health and that of others. The key, however, is partnership. It is incumbent upon the adult world to extend that trust – together with the means for acting on it – so that the young can help to achieve a healthier world now and in the future. ■

Society should do everything possible to help young people to plan ahead.

Dr Herbert L. Friedman is Chief of the Adolescent Health Unit, Division of Family Health, World Health Organization, 1211 Geneva 27, Switzerland.

Emerging needs of the elderly

Manuel Carballo

Over the next 40–50 years, the world's population aged 65 or over will rise from 184 million to 678 million. The immediate challenge is to address the needs of the elderly in ways that will give quality of life a high priority.

The 20th century has been one of profound social and demographic change. Almost everywhere, albeit to different degrees, infant and young child mortality has decreased, birth rates are falling, and life expectancy has significantly increased. Together, these changes are now altering the ways in which societies are organized and function, and are calling for a major readaptation on the part of governments, communities, families and individuals. At the same time as the life span of people has increased, so has their physical potential to function well in society; so now there is the need to provide them with the required psychosocial space if they are to continue contributing to, and enjoying, the fruits of society.

Demographic effect

Today, some 31 countries each have over 2 million citizens aged 60 and over, and by the year 2025 it is estimated that there will be 1200 million people in this age group, i.e., over twice as many as there were in 1990. As with other health developments, the "greying" of society has been most obvious in the richer, more economically developed countries. In Europe, for example, where birth rates have been falling and where living conditions have been steadily improving for much of this century, some 20% of the region's population is now aged over 60.

This trend towards "older" societies is spreading geographically as a result of improved social and economic conditions. For example, in Japan and Singapore, by the year 2025, people aged 60 and over could constitute 29% and 27% of those countries' populations respectively, whereas in Sweden, where over 20% of the population is already aged over 60, by 2025 it will have increased to 30%. In China the year 2000 will see more than 80 million people aged 65 and over, and India can expect a similar figure to be reached by the year 2015.

Changes in life expectancy depend on many factors. Not only do social and economic conditions play an important role, but the quality of, and access to, health and social services are also an important and necessary ingredient. However, no social and demographic change of this magnitude can occur without, at the same time, provoking new demands and new challenges. The aging of society is no exception to this rule, and the coming years will test the capacity of society and its institutions to respond meaningfully to the broad health and social needs of older people. The first challenge results from the evolution of the family during this century. Smaller, more mobile and more independent than extended family networks in

Grandmother and grandchild in India. People aged over 65 are forming a greater proportion of the population all over the world.

Longevity is something we all aspire to; but old age entails special hazards that need to be addressed by the health sector.

the past, the contemporary family is less able or prepared to care for older relatives than before.

Another challenge concerns the changing face of employment and the need in many countries for older people to retire earlier in order to make way for younger colleagues. The elderly are thus faced with the growing contradiction of being physically fitter for longer than before, but at the same time being confronted with longer years of economic inactivity.

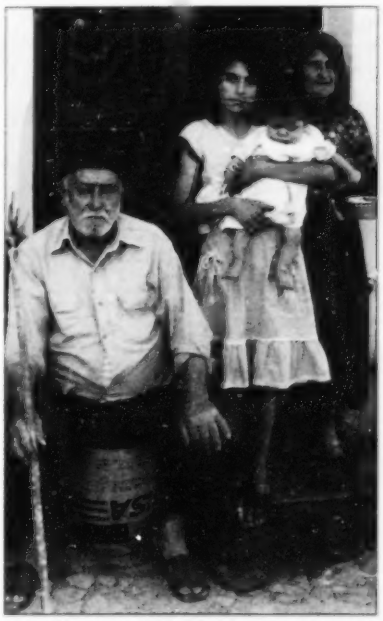
Meanwhile, social attitudes to the elderly have also changed. Because they are seen as physically fitter (which for the most part many of them are), and more mobile and economically independent, they are also thought to be more psychologically able to cope for themselves than before.

Facing the problem

Yet no matter how healthy or autonomous older people appear to be, the fact remains that age brings with it the heightened risk of a variety of degenerative diseases and psychosocial concerns. Cardiovascular diseases, diabetes, osteoporosis, difficulties of hearing and vision, as well as Parkinson and Alzheimer diseases and dementias, are all more common in the later years. While many of these problems are becoming treatable, they show few signs of being curable. Instead, they are becoming the chronic diseases of modern society, often difficult to manage socially, and ever more costly to manage medically. The psychosocial needs of the elderly also become more pronounced with age. The need for companionship, the need to feel wanted, and the need for social and emotional support are central themes in the everyday lives of older people.

The question of how to prevent or deal with the medical and social disabilities of older people has thus become an overriding concern which will continue for years to come. Society will need to find ways of involving older people while maintaining and respecting their autonomy, and at the same time providing them with the support they require in the later years. In some areas, this is required even though the proportion of economically productive people who are able to contribute to the financing of the public sector services is decreasing. Society may need to find new adaptive social, medical and public health mechanisms because the cost of services is increasing for the elderly and outpacing the capacity or desire of society to deal with these issues in the way it used to.

Autonomy and the ability to be active enhance the quality of life for elderly people.



An important factor in the quality of life for elderly people is their continued integration with younger generations.

This challenge calls for imagination, commitment, and in the context of many societies, a rethinking of health and social policies. Everywhere, it will require reorganization of health and social services, and training of new cadres of workers able to cope with the needs of "greying" populations. It may require new societal approaches to the biological family and to "surrogate" families of choice, and especially to finding ways in which they can be supported so that they, in turn, can relieve some of the pressure from the formal sector. Everywhere, longevity as one of the fruits of social development will call for more attention to be paid to the quality of life as well as to the number of years lived. ■

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A West African initiative

Véronique Lawson

African women have a greater participation in their countries' development when they form part of the active labour force.

The West African state of Benin is encouraging women from all spheres of society, including those who are unemployed, to participate more directly in activities that will help the country's development.

The Association of Beninese Women for Development (AFBD) first saw the light of day in January 1990. Officially recognized and with around 500 fully registered and active members, it is a federation of many women's groups and covers the entire national territory. Its ranks include a wide variety of professions: physicians, pharmacists, lawyers, civil servants, engineers, economists, technicians, teachers, midwives and nurses, pensioners, businesswomen, housewives and unemployed women.

The AFBD has a General Assembly and an 11-member Executive Board charged with carrying out all decisions emerging from the General Assembly. It also has several technical commissions designed to promote new ideas and programmes in the various fields of activity. But perhaps the most important features are the "cells" – decentralized and self-supporting organizations of women living in town suburbs and villages – and the "cell-groups," which are extensions of the cells and operate as cooperatives for women engaged in the marketing and processing of farm produce.

The Association's principal objective was to encourage more women to participate more intensively in the process of democratization. Next, it sought to bring all the women together to promote the country's economic development through income-generating activities. These would not only help them to raise their families' standard of living but also enable them to make savings so as to cope better with any health problems that might arise.

With these objectives in mind, many cooperative groups have benefited from the support of the AFBD network to improve the quality and value of their produce. For example, the Association has set up two cooperative projects to encourage young unemployed people to raise pigs, and it is overseeing a women's cooperative which is undertaking market gardening on the country's Atlantic coast. To support such activities and give the women easier access to credits, a savings cooperative called Coopec-Fraternity was started two years ago.

So that Beninese women can derive greater benefit from their economic activities and thus promote development, some 30 members of the AFBD have received training to train others in the running of microprojects; this is part of a project aimed at financing health through small, economically viable projects initiated by women and unemployed young people.

This year and next year, the AFBD programme envisages 200 microprojects which are being put into effect by women and the young unemployed. These projects will help women to involve themselves actively in the productive sector and to make savings that will ensure the financing of their families' health through the creation of mutual funds for social welfare. ■

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Women, sexuality and AIDS in Brazil

Maria José Oliveira Araujo & C. Simone Grilo Diniz

Barrier methods of contraception, and above all the sheath, help to prevent not only unwanted pregnancy but also sexually transmitted diseases and AIDS. This is a priority message for family planning programmes in today's world.

Traditionally, family planning programmes have placed little emphasis on the context in which sexual relations take place or on the ill-treatment of women at home and in society. They have shown little solidarity with women's efforts to improve their social position. Only recently, within the concepts of the comprehensiveness and quality of care, have such issues as the hierarchical relationships between the sexes, domestic and sexual violence, and non-consenting sex begun to be discussed. Considering the seriousness of these problems, they are still discussed very timidly.

Public opinion surveys show that the idea is still prevalent that HIV infection/AIDS occurs only in "risk groups", identified as people whose sex life does not follow conventional patterns, such as male homosexuals, prostitutes and the promiscuous. The facts are very different: recent worldwide data show that women now represent a considerable proportion of all infected persons. If men and women are to be free from such infection, they need to practise safer sex, above all by using the condom. For women this presents an additional problem, since it is the men who need to use it, very often in contexts where the women have little or no control over their sexual availability, and where the refusal of sex or the suggestion of using a sheath could bring the risk of rows, violence or abandonment by the partner.

Another serious problem with family planning programmes has been the emphasis on high-technology methods that are extremely effective but over which, again, the woman has little or no control; they involve a high degree of dependence on family planning services, and provide no protection against sexually-transmitted diseases. In the countries of the South, barrier methods are used much less than in the countries of the North. Priorities in the South are based on reducing population growth and on the belief that women could not cope with a method that they had to apply themselves, whether through lack of education or because they carry too little weight in their relationship with their partners. In Brazil, as in other countries, the cost of motherhood for women (material and emotional cost, extra work, etc.) leads 85% of female contraceptive users to opt for pills or surgical sterilization.

Women's efforts to improve their social position have still had little impact on family planning programmes

A further problem is that, in some countries, while women are required to be monogamous, the man is allowed to have other relationships.

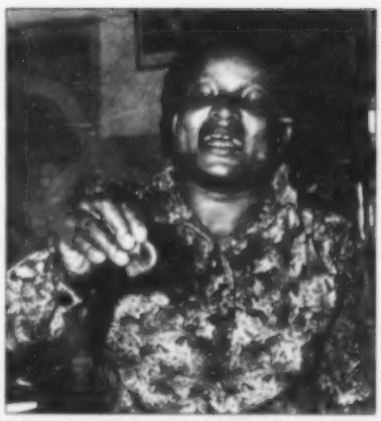
Family planning and AIDS

The AIDS epidemic makes it extremely urgent for society as a whole, and for family planning programmes in particular, to reformulate their role on the basis of an understanding of who decides how, when and why to have sexual relations, and to honour a commitment to promote greater awareness and negotiating power for women. Very often, such programmes still offer the only possibility of access to any kind of social service, especially in the context of overall poverty in the countries of the South.

The worldwide movement of women has stepped up its struggle for access to safe contraception and abortion, and for wider recognition of their reproductive rights. The fight for these rights introduces a new logic into the efforts to build up women's citizenship, by regarding motherhood as useful work, and thus as something that they should freely choose with the support of society. Thus women become active participants in reproductive and sexual choices. In the countries of the South in particular, this implies radical changes in the relations between the sexes. As rates of HIV infection/AIDS among heterosexuals increase, the relationship between socioeconomic status and risk behaviour becomes clearer – and once again women are the poorest among the poor. In São Paulo, Brazil, where AIDS is already the leading cause of death among women aged between 20 and 35, these women have substantially lower incomes and less education than men with the disease.

There is an urgent need to increase the available financial resources and to change family planning policies:

- By incorporating the awareness that the sexual relationship is one that empowers people at different levels. Everything suggests that the most effective solution is to increase the negotiating power of women.



Promoting condom use. Barrier methods help to prevent unwanted pregnancy as well as sexually transmitted diseases and AIDS, and cervical cancer.

To plan their families and practise safe sex, women need greater negotiating power vis-à-vis their partners.

- By re-evaluating family planning methods on a basis of the risks of HIV infection, either because the methods do not prevent it or because they increase the risks. For example, the IUD presents a risk by facilitating pelvic infection. In Brazil, the high rate of tubal ligations makes women more vulnerable, since they find it harder to insist on a barrier method when there is no longer any need for contraception.

It is vitally urgent to give priority to methods that combine contraception with prevention of sexually transmitted diseases. Barrier methods, which help to prevent an unwanted pregnancy as well as these diseases and cervical cancer, must be given priority if we are committed to the sexual and reproductive health of women – indeed of the whole human race. ■

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AIDS: no immediate demographic repercussions

Is there a danger that AIDS might depopulate the planet? The question is constantly asked, and it reflects a real but unjustified anxiety. Despite the vast scale of the epidemic in every continent and the dramatic inroads that it is making, the world population is not threatened with self-destruction as things stand at present. The five countries hardest hit by the epidemic are grouped in sub-Saharan Africa. Between 7% and 9% of the population of Malawi, Rwanda, Uganda, Zambia and Zimbabwe are infected with HIV, but rates in the big cities and more seriously affected zones are approaching 25%.

While the impact of AIDS in terms of individual suffering and of social and economic cost remains intolerable, in demographic terms it is barely noticeable. The fact is that the rate of demographic growth of these countries exceeds 3%, and this largely compensates for the negative effect of deaths from AIDS. Paradoxically, the poor performance of organized family planning programmes (an average of only 13% using contraceptives) protects these countries from recording a drop in population. The effect would be quite different if contraceptive use were as popular in these countries as in other continents. In the present situation, only if as many as 50% of the population were infected with HIV would there be immediate demographic repercussions.

Health, population and development

The goal of economic development is human dignity and well-being, an essential ingredient of which is health. Progress in sustainable social development necessarily reflects the health status of the population, so that Health for All must become one of the guiding principles within the larger framework of sustainable development.

Following the Second World War, international development efforts in developing countries concentrated on the reduction of mortality. By the end of the 1960s, the anticipation of excessive population growth led to a revised concept of health and development assistance. Today, the challenge of the International Conference on Population and Development, to be held in Cairo in September 1994, is to ensure that population policies are carried out as part of a general effort to improve the health of individuals, and to shed light on the complex interactions which exist between health, population dynamics and development.

Health systems need to respond effectively to changes taking place in the growth, structure and distribution of the world's population, for instance by intensifying activities within the primary health care framework and creating new responses to global population changes. Health initiatives must not lag behind changing population needs; the analysis and interpretation of population structure and dynamics should be an intrinsic part of the planning and delivery of health services.

Health policies should make provision for support to the family

WHO is working with other agencies and with concerned nongovernmental organizations to convince all countries that health is a cornerstone of development. Human energy and creativity cannot be generated by sick, tired people; a healthy, active population is a prerequisite for economic development.

The needs of the young

About 80% of the world's population aged under 25 live in developing countries, and by the year 2000 this level will have risen to around 86%. Education, job opportunities, housing and health services tailored to the needs of young people at all stages of their early life need to be developed. Health programmes must promote and protect adolescent health, not least by conveying the message that unsafe sexual behaviour can result in unwanted pregnancy, unsafe abortions, and sexually transmitted diseases including HIV/AIDS.

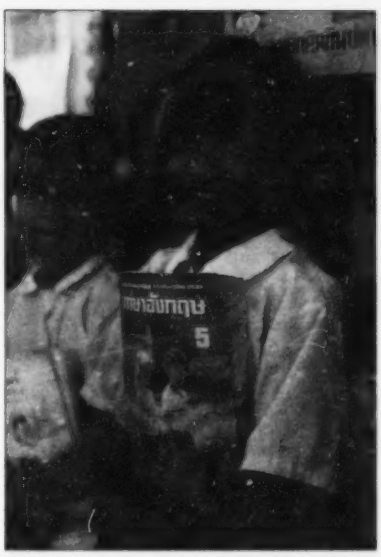
Meanwhile growth of population and production with unsustainable consumption are putting a strain on "planetary life-support systems", affecting the use of land, water, air, energy and other resources. Unmanaged rapid growth of cities in particular puts great pressure on environmental resources and creates significant problems of waste.

The global population aged 55 and over is increasing by nearly 1.3

million each month, some 80% of that increase occurring in developing countries. By 2025, the proportion of the global population aged 65 and over will reach 800 million people compared with less than 300 million in 1990. Their health needs will call for special provisions.

At the other end of the scale, young couples must have access to fertility regulation that allows them choice and self-determination in matters of health and family size. Family planning associations, women's groups and the relevant nongovernmental organizations can play a major role in reaching different social groups. Increased efforts must be directed towards ensuring that men assume their responsibilities in this field.

In taking up the challenge posed by changing population dynamics, the authorities must see family health as a key element in social policy. The stability of the family, no matter what its form, must receive support, especially through policies for health. In this regard, more attention should be given to the rights of women as individuals, and steps must be taken to acknowledge the conflicting demands made on them as providers, carers and wage-earners.



Health education has to be tailored to the future needs of young people

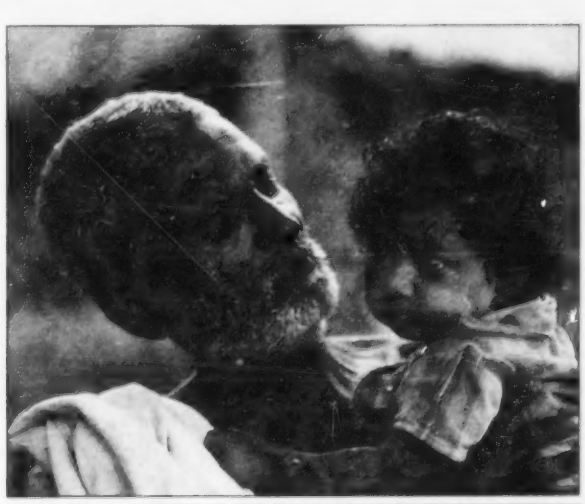
A healthy reproductive life is essential to attain the goals set for infant and child survival. Reproductive health specifically implies that people have the ability to reproduce, to regulate their fertility and to practise and enjoy sexual relationships. Greater spacing of births would substantially reduce worldwide child mortality, while the increased chances of newborn babies surviving will eventually influence couples to reduce the size of the family, and this will contribute to lower population growth.

The provision of information, guidance and support to enable people to enjoy a healthy, safe and fulfilled sexuality is a fundamental responsibility of any truly comprehensive health care system. Equipping individuals with the knowledge and ability to protect themselves, their partner or their family from the potential hazards of unsafe sexuality has always been important, but with increasing exposure to sexually transmitted diseases, especially among young adults, and the spread of HIV/AIDS, the need to promote healthy sexuality has become urgent.

In addition, the loosening of traditional constraints on sexual behaviour as a result of chaotic urban growth, migration, conflicts, disasters or social and economic degradation make it all the more vital for health policies to take steps to promote healthy sexuality to prevent the spread of disease. Health and population policies must respond to the needs of individuals and communities for information, support, and counselling on sexuality, as these are all integral components of ensuring the health of individuals and families.

WHO's role in all these fields is to cooperate with governments and to urge them to provide health systems which meet the changing needs of individuals and populations. ■

Family planning: a key factor in the progression towards health for all



Development entails covering the specific health needs of all people, from the youngest to the oldest

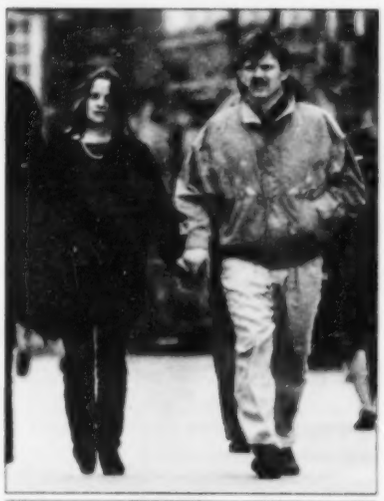
The long march from abortion to contraception

Daniel Pierotti & Chantal Blayo

Contraceptive production in Eastern Europe has collapsed everywhere except in Hungary. The unfamiliar market economy obliges countries to pay for contraceptives with foreign currency, and abortion is what is mostly resorted to by many women. Nevertheless, solutions are being found to the chronic shortages of contraceptives and – with patience – it may prove that the countries of the former Eastern bloc are just beginning their long march from abortion to contraception.

Every year, countries around the world report between 30 and 40 million legal abortions. The former Soviet Union and its East European neighbours (10% of the world's population) are responsible for one-third of these abortions. These facts lend support to the notion that these countries are specialists in this field.

Russia legalized abortion on request in 1920, followed two years later by the other Soviet republics. Its more recent allies fell into line at the end of the 1950s. The East European countries were thus unique in having legalized abortion before the advent of the contraceptive revolution, and some 15 to 25 years before the countries of the West followed suit.



All couples should have the right and possibility to plan the number and spacing of their children

The abortion laws vary widely, some countries being more restrictive than others, and some have taken a step backwards. The best known and most tragic case was that of Romania with its annual toll of hundreds of women dying from clandestine operations, the terrible consequence of a double legal ban on both abortions and contraceptives. But in general the climate favoured the introduction of a policy of legal abortion, except in those countries with a strong moral or religious tradition; only Poland and Lithuania, both strongly Catholic, distanced themselves somewhat from this model.

Recourse to abortion still remains very widespread in the 1990s, ranging in the countries of the former USSR from 2.5 to 4 abortions per woman and for the rest of Eastern Europe around 1.5. By contrast, in the West the figure is no higher than 0.63 per woman. The difference is even more striking as regards the type of woman who seeks an abortion. In the East, she is a married woman with a family, aged over 25, who has already aborted and returns for another. In the West, she is an unmarried woman with no children, aged 20 or less, requesting her first abortion.

Broadly speaking, in Western Europe, abortion represents an isolated accident – a contraceptive failure; repeated abortions are unusual because contraception is universally practised. In Eastern Europe, however, abortion is still the preferred and often the only means of birth control; except in a few countries such as Hungary, family planning is limping along.

An international conference held in October 1990 in Tbilisi, Georgia, specifically aimed at the Eastern countries, proposed a plan of action based on three essential principles:

- the fundamental right to plan the number and spacing of children;
- the big public health problem stemming from unwanted pregnancies and abortions carried out under non-surgical conditions;
- the promotion of contraception and an effective strategy to reduce abortions.

Three years after that conference, no substantial changes can be seen. The legalization of abortion in Romania

and Albania suggested a certain progress but was overshadowed by the disturbing potential of a new law restricting abortions which was approved in 1992 by the Polish parliament.

As for contraception, efforts have only rarely been successful. The situation generally remains static because of economic stagnation, organizational collapse and lack of motivation on the part of health professionals, not to mention the destabilizing effect of ethnic conflicts in many states. In 1994 the smooth transition from abortion to contraception seems more like a distant dream than a fruitful and desirable goal. Most of these countries are bogged down in disastrous social and economic crises, and demographic trends are alarming in the sense of non-renewal of the generations (other than in the Asian republics of the former USSR). Contraceptive production has collapsed everywhere except in Hungary. The new laws of the market economy oblige countries to pay for contraceptives with foreign currency, while modern methods are in direct competition with desperately needed essential drugs and basic medical equipment.

Long before the advent of modern, effective and user-friendly contraceptive methods, men in Western Europe had accepted responsibility for the traditional forms of contraception: the condom in the North, withdrawal in the South. Men in Eastern Europe have forgotten such practices and this apparent lack of interest in traditional methods, in conjunction with the shortage of modern contraceptives, plays a big part in increasing the numbers of abortions.

Care-givers have an essential role to play and physicians can do much to improve the situation. But the weakness of their training in this field and their basic lack of belief in contraceptives, as well as the unavailability of the most up-to-date methods, make it unlikely that they will change their ways and campaign for contraception. Moreover, the fact is that the present plague of abortions is a source of considerable and regular income for the doctors. The former networks and traditional supervisory patterns have not been replaced by anything new, and the attitude of individual survival and "everyone for himself" predominates to the detriment of the quality of public service and of contraceptive care intended for women.

The donor agencies and those responsible for specialized techniques maintain their reserve; the fall of the Berlin Wall has not given Eastern Europe any special priority, and the opening of frontiers has not been followed by a windfall of technical and humanitarian assistance. Some urgent contraceptive aid has been provided to the most needy countries and a few limited programmes have appeared. As for any common interagency strategy, that has yet to be created.

However, the situation is not quite as dramatic as it seems. Eastern Europe is passing through an acute period of crisis which affects all social and economic aspects of society – health included. This crisis cannot last for ever. Already there are some indications of recovery. This region has many advantages, with an educated population, economically independent women, a high proportion of doctors, and health indicators approaching those of the West. In the field of birth control, more and more care-givers are getting specialized training either abroad or locally, while the news media operate across the frontiers and facilitate exchanges of information, encouraging new partnerships to be formed. Ways are being found to solve the chronic shortages of contraceptives. Foreign aid is gradually being mobilized.

Patience is hardly the first attribute of decision-makers and politicians. But with patience it may be seen that the countries of the former Eastern bloc are just at the beginning of their long march from abortion to contraception. ■

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Schoolchildren in Romania, a country which shares with others of Eastern Europe the advantages of a good level of education.

Family planning in sub-Saharan Africa

Iqbal H. Shah

Fertility rates in the countries of sub-Saharan Africa remain at high levels for traditional and cultural reasons. Now the beginning of a change is becoming apparent as more governments undertake a political commitment to birth-spacing.

Africa, the land of immense natural beauty and a rich cultural heritage, has fascinated travellers, missionaries and many others for centuries. The interest of social scientists and development planners is relatively recent, however, and focuses on the persistence of high fertility in the region. When information about a decline in fertility in Botswana, Kenya and Zimbabwe emerged recently, some heralded it as the beginning of a new era for Africa. Many wondered if sub-Saharan Africa was finally on the brink of a contraceptive revolution that would mark the onset of widespread fertility decline. Others remained sceptical about such a prospect.

Patterns of childbearing vary across Africa, whose population accounted for 10% of the world population in mid-1992. Despite much variation in language, customs and taboos, a common cultural vein runs through much of sub-Saharan Africa which is reported to sustain high fertility.

During 1985-90, the overall total fertility rate (i.e., the number of children a woman is expected to have by the end of her childbearing age) was estimated at 6.3 children per woman for Africa as a whole, as compared to 3.4 for Asia and Latin America. In most of the sub-Saharan countries (33 out of 46), fertility remains at levels of six or more children per woman, while only in two small countries (Mauritius and Reunion) is fertility below four children. Rwanda has the highest reported fertility, with 8.5 children per woman. Fertility rates in five countries (Ethiopia, Kenya, Nigeria, Tanzania and Zaire) which account for nearly half the population of sub-Saharan Africa, fall in the narrow range of 6.7-7.0 children per woman.

Contraceptive use in sub-Saharan Africa continues to be low. In the countries for which information on contraception was available, less than 10% of married women of reproductive age used any method of contraception, including traditional or indigenous methods. Among the five countries with large populations, only in Kenya was one in three women using a contraceptive method. In Nigeria, with the largest sub-Saharan population of 116 million people, only 6% of married women were using any method. Demographic history in other parts of the world shows that no country has achieved a transition to lower fertility without a contraceptive prevalence of at least 50%.

Among these countries, the oral pill is the most widely used method, followed by the intrauterine device (IUD), injectables and female sterilization. Of note is the fact that 5% of women in Kenya and 4% in

High fertility patterns in sub-Saharan Africa may be linked with culture.

The pill is the most widely used contraceptive method throughout Africa.

Schoolgirl in Zimbabwe. The higher their level of education, the more likely women are to have control over their fertility.

Botswana have undergone sterilization, contradicting the widely held view that this method is totally unacceptable in any sub-Saharan African country.

Elusive goal

Why have the widespread rise in contraceptive use and the accompanying fertility decline eluded Africa for so long? Are African social structures so deeply established and immutable that high fertility will persist? High fertility in sub-Saharan Africa seems to have been sustained by certain long-standing traditions: the high value attached to preserving the lineage; the importance of children for gaining access to resources, particularly land; and the weak nature of conjugal bonds. Additional factors are: a large percentage of the population living in rural areas, low levels of socioeconomic development, poor infrastructure, and high rates of infant and child mortality (one in every 10 newborns dies before reaching the first birthday in most countries). Moreover, until recently, most African government officials have expressed little support for family planning.

Bonds between husband and wife are typically weak; the "western" model of the individual couple as a well-defined unit within which all resources are pooled and from which all decisions flow, including those related to reproduction, does not hold true for sub-Saharan Africa. There is generally a separation of male and female budgets and of child-rearing responsibilities, with the husband typically making the decision regarding childbearing and the wife bearing the costs for child-rearing. The marriage bond is further weakened by the presence of co-wives.

Historically, the basic pattern of fertility limitation was birth-spacing through prolonged breast-feeding and the associated post-partum abstinence from sex. Although such traditional birth-spacing continues, increased urbanization, education and access to baby-milk formulas have contributed to its breakdown. At the same time, modern contraceptives are seen as controversial due to the fear of rejection or reproach by one's spouse, in-laws and friends, and because of self-doubt over the wisdom of using them.

Prospects for change

The varied socioeconomic development and the government policies of sub-Saharan African countries do not lend themselves to a straightforward assessment of the prospects for fertility decline. However, the recent upsurge in contraceptive use in Botswana, Kenya and Zimbabwe indicate the acceptability of modern contraceptives; their use rose on average by 1.2 percentage points per year in Kenya; 1.9 points per year in Zimbabwe; and 3.3 points per year in Botswana.

The health benefits of family planning are increasingly being recognized by African governments and political commitment for birth-spacing is growing. In an unprecedented move, African leaders collectively endorsed family planning and the need to integrate it into maternal and child health programmes in the 1984 Kilimanjaro Action Programme.

The spread of HIV infection and AIDS has introduced a new dimension. Many couples are reported to be reducing their desired family size since they may have to look after the children of their relatives destined to die of AIDS. On the other hand, they may be motivated to have more children due to the perceived high risk of infant and child death. Eventually, improvements in female education, infant and child survival, and the strengthening of family planning services are likely to provide the needed impetus for increased contraceptive use and fertility decline in the region. ■

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What do women want?

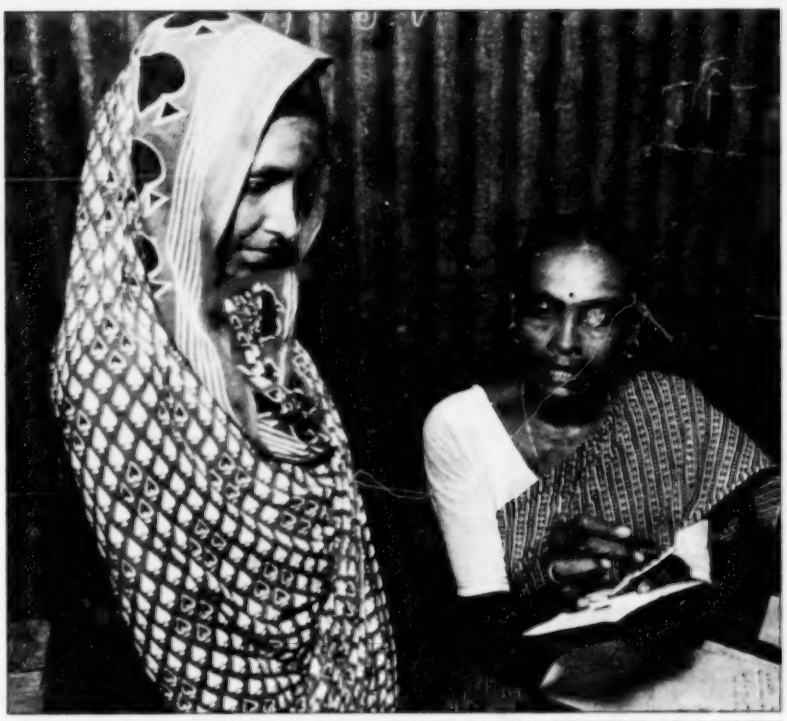
T. K. Sundari Ravindran

Almost 30 years after the contraceptive revolution of the 1960s, there are 300 million couples in the world who do not want any more children but are still not using any form of contraception, when there are more than 70 different types of contraceptive pills, at least 20 IUDs and four types of injectables, barrier methods, and female and male sterilizations.

Take the case of Gowri, aged 29, a poor wage labourer living in a small town in South India who is anxious to avoid any future births, but has not found a suitable method of fertility regulation. She has had six pregnancies and borne five children, of whom only the fourth and fifth survived. The first was a stillbirth while the second, a girl, was born mentally retarded and died after the second year. The third, a low-birth-weight baby, did not survive beyond the first hour.

"I was heart-broken. My husband had turned to another woman because I was unable to bear him a live child. When the fifth child was barely a year and a half, I was pregnant for the sixth time. That was when I decided to have an induced abortion to ensure that the two precious ones grew up healthy and well cared for."

Being dependent on daily wages for survival, she could not afford the long delays involved in seeking help from a government hospital. She borrowed money and went to a private clinic, where she had an abortion and had an IUD inserted right away. Following this, her menstrual bleeding lasted nine to ten days instead of five. Already malnourished, she became acutely anaemic. Then she developed an infection of the reproductory tract during the second year, mainly because of the lack of privacy, limited access to water and inability to afford adequate sanitary protection during menstruation. This seriously disrupted her ability to do strenuous work, and in addition the medical treatment proved very costly.



The choice of a fertility regulating method depends on many factors, including affordability

Unable to continue with the method, Gowri switched to oral pills bought across the counter. But she could not afford to buy them month after month. She also had spells of dizziness and vomiting, and felt very weak and unwell. "I often had to take breaks during work and lie down for a while." Soon, no one was willing to employ her since she was considered sickly. This left her with no choice but to discontinue the pill. Tubal ligation is the only other option available, but she has reservations. Her children are still too young, and she wants to wait till they live to be older. In addition, she has no one to take care of them, or of her, after the surgery. She could not afford to stay away from work for several days, either. Expecting her husband to adopt birth control is a hopeless idea, since he now has another family, and visits Gowri only once or twice a week.

Facing realities

For women, the safety of any contraceptive method is defined in relation to whether it has adverse health effects that limit their ability to carry on their normal daily tasks, and to earn a living; whether these effects involve costs for medical treatment to alleviate the symptoms; and whether they cause or accentuate marital tensions because of the effects on the woman's physical and emotional well-being, and on her libido.

Acceptability too is based mainly on factors such as the point at which women are in their reproductive life-cycle and their reproductive history. Women who have suffered child losses and pregnancy wastage would not accept methods that may interfere with their fertility – present or future. Young women who have not begun childbearing and women who plan to have additional children may find a less effective method acceptable, especially if it is free of health risks – as in the case of natural family planning or barrier methods. Women who are wage-earners may be unable to afford taking time off work to go to the clinic regularly, for injectables or to replenish supplies of oral contraceptives. Thus, acceptability of a method is assessed by women according to the circumstances of their lives; they are likely to vary for different women, and for the same woman at different points in her life.

Fertility control should be a matter for both partners to decide on.

Male-dominated society

Acceptability of a contraceptive method is also judged within the parameters of a male-dominated society. Men rarely come forward to undergo sterilization, and are usually unwilling to use the condom especially for contraceptive purposes. Often, women themselves reject the idea of male sterilizations, because they do not want the "breadwinner" to take any risks with his health.

In discussions with poor women in rural India, I often heard remarks such as the following:

- "I do not trust the service provider to remove the implant if I have a problem. I do not want to risk it."
- "They (service providers who are part of the government's family planning programme) do not take responsibility for treating reproductive tract infections that may follow IUD insertion; you have to seek help from private doctors, and that costs money."
- "I am afraid of all methods. All of them have problems, and the service providers don't care."

Thus, many of the reasons why women do not find a fertility-regulating technology that suits them have to do less with the technology itself, and more with their poor health and overall status; with male control over female sexuality and men's unwillingness to take responsibility for fertility control; and with a poor health infrastructure and quality of care. What is needed is a search for policies and programmes that will remove these constraints.

More importantly, women's needs and concerns should be the starting point on which the development of new fertility-regulating technologies are based. This would involve the search for methods that are not only free from adverse health effects but also provide protection from reproductory tract infections and HIV/AIDS; that are reversible and do not adversely affect future fertility; that do not interfere with lactation; and that are in addition effective, easy to use and affordable. It would also mean according a high priority to the development of a wide range of contraceptive methods and devices for men. ■

Poor health and low overall status are often barriers that prevent women from using contraception.

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Health in a city environment

Françoise Barten

Rapid urbanization creates marginalized communities who live in desperate poverty and may represent up to half the population of some developing countries.

Partners from North and South are working together on a variety of urban projects. The aim is to contribute to improvements in city living standards well into the next century.

Rapid urbanization and the increase in urban population are recognized as being among the major challenges for health development in the 1990s and in the decades to come. Between 1950 and 1980 the world's urban population increased from 701 million to 1983 million, or from 25% to 41% of the total world population; by the year 2000 this proportion will be 50%. Change has been particularly rapid in the South, where the scale of urban growth is unprecedented in human history and cities have experienced growth rates two to three times higher than those of industrialized countries in the past. Between 1990 and 2025, the total urban population in "developing countries" is projected to increase threefold, to 4000 million or 61% of the population.

Urbanization is taking place in a context of increasing poverty. As much as half of the population of cities in the South live in conditions of extreme poverty associated with enormous deficiencies in such basic services as water supply, sanitation, sewage systems, drainage and basic health care. A key-feature – and one of the most important reasons for concern – is the existence of gross inequalities in health and environment between cities and between richer and poorer areas within the same city. In Guatemala City, for instance, the poor who live in the slums on the slopes of La Limonada – a ravine which crosses the city centre – have no water supply while just opposite, in the graveyards of the rich, fountains spray water all day.

Health problems are complex and poorly defined. Apart from the diseases of poverty (infectious diseases, malnutrition), the poor are exposed to the health risks of modernization (traffic, pollution, etc.) and suffer the consequences of social and psychological instability as the traditional support structures of the rural area steadily disappear. Most people in the Third World cities struggle to survive by participating in the informal or hidden economic sector where exposure to occupational hazards is of very little concern. Recent emphasis on this sector as a strategic approach to urban development tends to neglect the fact that small-scale industries may also constitute important environmental health hazards for communities living nearby.

While the environmental problems are wider in scope and far more serious in terms of impact on human health than those in cities in the North, the capacity to respond to such problems is also more limited. The absence of effective local governance certainly aggravates them. Health authorities have to cope simultaneously with three distinct disease profiles – infectious diseases, degenerative diseases and problems caused by environmental, occupational and social conditions – whereas it took industrialized countries more than a century to confront these three.

Focus on the vulnerable

If the health sector is to focus on so-called "vulnerable groups", it should be recognized that this refers to 50% of the population! It is clear that many problems cannot be addressed without fundamental changes in the distribution of incomes, both nationally and internationally.

However, the cities also offer many opportunities for change; and an integrated approach to health and urban development involving all actors at city or district level (local

Children in slum areas are subject to environmental hazards that may threaten their health and even their lives.

government, community organizations, nongovernmental organizations (NGOs), professional groups) appears to be the most promising line. In Manila, the recently accepted Local Government Act allows NGOs and community-based organizations to participate in district and subdistrict planning, including health. During the past decades, NGOs of various backgrounds had already acquired extensive experience in bottom-up approaches. Community-based organizations were developed in some cities in the 1970s, with land tenure as the main issue. However, health also proved to be important in the efforts to mobilize and raise awareness among the people. In due course, universities and other training and research institutions played an important role in supporting local urban health systems and in addressing policy questions.

North–South collaboration

The need for new models to resolve the problems of the urban poor recently led to the formation of an innovative network programme, involving institutes in both the South and the North, and including the Nijmegen Institute of International Health which is acting as temporary secretariat (on a rotating basis). The programme, Health and Environment in the Cities, or HEC, is meant to be a continuous working platform where partners from North and South collaborate on various projects. The "urban environment" is defined as the social, political, economic and physical environment, since all these factors interrelate and determine health in the city. The broad aim is to achieve equity in health, putting the key features of inequalities right up front. Because of the emphasis on inequity and the commitment to locally defined solutions and social participation, the prime focus is on the improvement of interventions not only in terms of design but also in terms of the processes of intervention.

Distinctive features are the multidisciplinary approach and the emphasis laid on information/communication to raise awareness and strengthen community-based organizations in the negotiation and planning process with local governments. This drives the network approach along a very different path from that of more conventional operational research and intervention studies.

Projects include those on the environmental and occupational health hazards of small-scale industries (Dar es Salaam, Tanzania), living and working conditions of scavengers (Jakarta, Indonesia), designing women-friendly health care (Managua, Nicaragua), determinants of violence (Kingston, Jamaica), urban health management and so forth. Besides these countries, HEC includes member institutes from India, Netherlands, Switzerland and the United Kingdom.

The initiatives, formulation, execution and evaluation of research projects, accompanied by operational research, come from a local level. The medium-term goal is to build the capacity within each society to identify, analyse and act on their own environment-related health problems; considerable emphasis is therefore given to participatory network methods and approaches. In this way, the HEC group hopes that its joint North–South programme will contribute to sustainable health and urban development – including the alleviation of poverty and inequalities – in selected cities well into the next century. ■

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Small-scale informal industries offer the only means of survival for many people in periods of serious unemployment.

Population growth and disasters

Samir Ben Yahmed

Hardly a day now passes without news about a major or complex emergency happening in some part of the world. Disasters continue to strike and cause destruction in developing and developed countries alike, raising people's concern about their vulnerability to occurrences that can gravely affect their day-to-day life and their future.

Major disasters have had a big impact on the migration of populations and related health problems. More than 20 million refugees and around 30 million internally displaced people are struggling for minimum vital health needs, boosting the toll of many millions who lack basic health services, have no access to safe drinking-water and suffer from malnutrition. In many places, for instance in parts of Africa, displaced people resettle on their own without claiming official status as refugees or displaced persons, so that even these figures do not convey the true picture.

The Department of Humanitarian Affairs in the United Nations has registered a 35% rise in the number of complex emergencies between 1991 and 1993. These alarming figures pose the following burning questions.

- Are disasters simply fatalities which humankind is condemned to suffer?
- Why does the rise in disasters closely parallel the rise in population growth?
- Why do disasters cause much greater havoc to poor countries than to rich ones in terms of human lives lost and property destroyed?

Vulnerable populations

Emergencies, especially those that occur in nature, only become catastrophic events when they combine with vulnerability factors, such as human settlements and population density. An earthquake occurring in a deserted area would be considered a natural hazard; but if it occurred in a megacity it would be recognized as a major disaster.

This is also true for complex emergencies. These are defined as "forms of human-made emergencies in which the cause of the emergencies as well as the assistance to the afflicted are bound by intense levels of political considerations. The single most prevalent political condition of a complex emergency is civil conflict, resulting in a collapse of political authority in all or part of a country." If we analyse population vulnerability within the context of complex emergencies, we will find that they amount, at their most basic level, to a competition for resources, often emerging as disputes over land, water rights, natural resources or jobs at global level.

The hazards that can result in emergencies must not be overlooked when population issues are being considered. Equally, it would be wrong to neglect the population dimension of emergency management.

Another type of emergency that has to do with population vulnerability concerns technological disasters such as those of a chemical or radiological nature. To build chemical plants in the middle of populated areas without the required safety measures and plans for emergency management can and does lead to technological disasters, such as at Bhopal and Chernobyl.

These examples demonstrate that major and complex emergencies are closely linked to anarchic population growth, leading to unplanned population settlements, environmen-

Demographic growth pressures force vast numbers of people to resettle in another region, often in very unsafe conditions.

tal degradation and poverty. The lack of minimum health services and basic education are aggravating factors which could make a disaster out of an emergency and a complex emergency out of social tension.

Emergencies and sustainable development

Population-related issues are usually dealt with in the development context, and only rarely in the framework of humanitarian action. But sustainable development cannot be cut off from humanitarian action and vice versa; these two issues are linked together in a single continuum or cycle.

The international community, including the United Nations, often speaks about this continuum from relief to development. The rationale behind it is that whatever is done in the relief phase following a major or complex emergency should lead to a better schema for sustainable development. WHO sees it as being a cycle in which emergency prevention, mitigation and preparedness are integrated so as to form part of sustainable development, thus leading to quick, well-planned and efficient humanitarian action in the aftermath of an emergency. Similarly, relief, recovery and rehabilitation efforts which are components of humanitarian efforts, can, if carefully thought out and implemented, strengthen the community's coping mechanisms.

In emergency situations, health care is the first and most crucial need of victims.

Issues on disasters and population are therefore best approached in an integrated fashion and with proper regard to the cycle from relief to development. The risks and hazards that can result in emergencies must not be overlooked when population issues are being considered in the development phase. Equally, it would be wrong to neglect the population dimension of emergency management.

In fact, emergency management and population issues cannot be dealt with by one sector or department alone. "Horizontal" cooperation among all sectors concerned is a must if any action to mitigate the negative effects of these two phenomena is to succeed. Therefore they need to be integrated into national socioeconomic and development planning and, together with such components as the environment, should become part of all programmes, projects and activities affecting people's lives. Public awareness, education and information, and the sensitization of community leaders are the key elements of a successful strategy to contain the problems of population growth as well as improve emergency management.

The International Decade for Natural Disaster Reduction (IDNDR), which fosters global efforts throughout the 1990s to reduce the effects of catastrophic events, is an ideal vehicle for the required change in global policies and strategies. If the scope is enlarged to encompass man-made disasters as well, it could lead to a real shift in the way we think about and handle these problems.

The theme "From disaster management to sustainable development", advocated by WHO, was a major feature at the World Conference on Natural Disaster Reduction, in Yokohama, Japan, in May this year. ■

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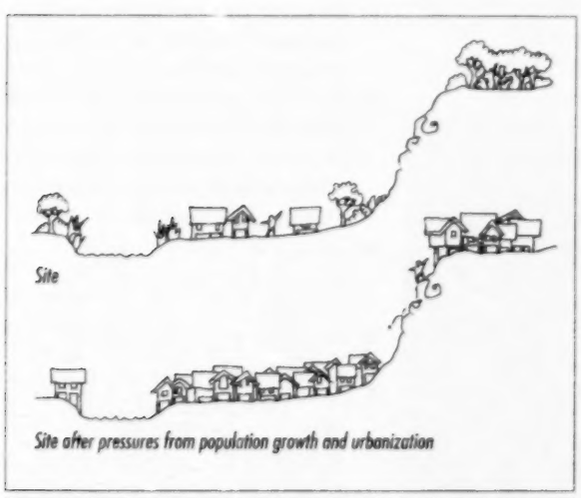
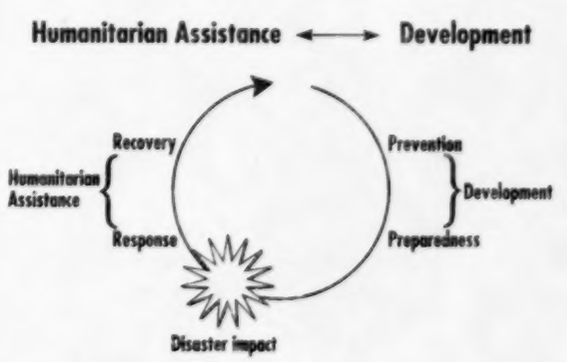


Poverty, population growth and urbanization oblige people to make their homes in unsafe areas.



The cycle that links disaster prevention and development.

Community action

Community-based family health

Oladapo A. Ladipo & Christie Laniyan

Delegates to the World Health Assembly and other health experts are invited to participate in Technical Discussions on a chosen theme of importance for international public health. This year the theme is "Community action for health", with the accent on the need for a dynamic partnership between health professionals and individuals in the community to ensure a focused improvement in each community's health status.

The deplorable health and population profile of many African nations results from a variety of factors. One way in which Nigeria is tackling the problems has been to set up the Association for Reproductive and Family Health (ARFH), a creative move to initiate and promote programmes aimed at improving reproductive and family health in Nigeria and elsewhere in Africa. The target groups for ARFH's programmes are the rural populace and the urban poor, through the primary health care strategy known as Community-Based Distribution.

ARFH's involvement in promoting this approach stemmed from an operations research study (1980-83) which was designed to test the feasibility of training community members as community-based distributors of health services, whether community health extension workers, voluntary village health workers or traditional birth attendants. After five years of joint management between the Fertility Research Unit in the Department of Obstetrics and Gynaecology, University of Ibadan, and the Oyo State Ministry of Health, the operations research programme was expanded to all the 23 local government areas of the state, with a community-based distribution unit set up in the Ministry of Health to oversee its implementation.

In 1986 the methods and techniques for recruiting, training, motivating and supervising rural community-based workers, most of whom were illiterate, were adapted to an urban-based project in the ancient city of Ibadan. While offering a somewhat simplified version of the health and family planning services provided by the rural model, the urban (or market-based distribution) project sought to test the use of market traders as agents for promoting health maintenance and family planning in city market places.

Talking about health and family planning with the women of the community

Work in the community

The programme focuses on training, supervising and monitoring community-based workers in:

- preventing and treating common ailments in the community such as malaria, diarrhoea, cough, worm infestations, minor cuts and wounds, and first aid;
- providing antenatal, postnatal and safe delivery care to pregnant women, when necessary by traditional birth attendants, while teaching them to recognize high-risk pregnancies or other dangerous situations and the need to make prompt referrals;
- motivating, counselling and providing information on family planning, including the distribution of non-prescription family planning commodities;
- using lower-level medical personnel as health services providers;
- community participation and involvement;
- ensuring project cost-effectiveness, cost-recovery and sustainability.

We now recognize nine steps in the process of establishing a community-based programme:

1. Project development

For a community to be supported, it should be disadvantaged in terms of socioeconomic status, accessibility and proximity to a health facility, and must acknowledge the need for self-help. A needs and resources assessment is carried out to determine what are the felt and latent health needs of the community, and what resources within or outside are required to meet those needs. Once a baseline survey has been made to obtain relevant socioeconomic data, a project is designed that will be appropriate, local and flexible, with community involvement at every level of development.

2. Community mobilization

Strategies aimed at sensitizing and mobilizing community members to become active in preventing health problems include advocacy, awareness generation, constituency building and networking. Active support and participation are sought from the traditional, political and religious leaders as well as from women's groups, men's organizations and youth groups.

3. Selecting and recruiting the workers

A community-based worker is usually a volunteer with special interest in serving others, ready to work with no incentives, and a resident member of the community with a known occupation and earning a means of living. The ability to read or write is optional. Final selection lies with the health professionals who are guided by the result of the baseline survey in the final selection.

4. Training

There are at least three levels of training. Management training focuses on the local government staff and community organization members responsible for project administration. Training-of-trainers is directed at those responsible for the training, supervision and monitoring of the workers. The third and most crucial level is the training of these workers, which seeks particularly to arouse their interest in acting as agents of change in solving health problems.

5. Supply kits

On completion of training, the workers are provided with a metal box kit containing drugs for treating common ailments, family planning commodities, record sheets and other supplies. These stocks are replenished on request.

6. Service delivery

Community-based workers provide health education on the causes and prevention of common ailments, dispense drugs to treat common ailments and distribute family planning commodities. The trained traditional birth attendants also provide antenatal, postnatal and childbirth services. It is impressed on the workers that they should recognize the limits of their skill and should make referrals in good time.

7. Record keeping and reporting

To enable the programme managers to assess the project, the workers are provided with records which they maintain in pictograph format. Their supervisors are responsible for collating and translating these records.

8. Monitoring and supervision

Various schedules, checklists and records are used to monitor and supervise activities. The aim is to assist the community-based workers to develop and use the skills they have been taught. When corrections are made, the purpose is not to chastise but to encourage the workers to appreciate the enormous value of their roles in the community as enhancers of the quality of life through health services delivery.

9. Evaluation

The needs and resources assessment and baseline survey reports provide the initial evaluation. The reports, records and spot checks provide process evaluation, while a final evaluation attempts to measure the impact of the project. Evaluation is seen as a continuous activity enabling the project managers to make changes when necessary.

Many lessons have been and are being learnt in promoting the community-based distribution approach to the delivery of health services and family planning in an integrated context. This approach is people-centred and community-oriented, and seeks to empower the people rather than trap them in a situation they do not understand. It allows for creativity and innovation as individual communities are encouraged to design a health delivery system that works for them. ARFH has succeeded in introducing similar projects across Nigeria by ensuring community participation in all phases of programme development, and these are serving to promote and strengthen firm links between the community and the formal health sector. ■

Motivating the community on the positive advantages of family planning

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Community-based distribution agents undergoing training with the help of locally made materials

WHO on . . .

Reproductive health

Regular care of pregnancy – by a trained health worker – an indispensable requirement for maternal health

On the eve of the Third International Conference on Population and Development (Cairo, September 1994), WHO once again sets its sights on the inseparable links that exist between global population dynamics and the everyday lives of individuals. Demographic trends are fundamentally influenced by choices made by individuals about their sexual and reproductive life. Hence the necessity for individuals to be given the possibility of making choices that will most benefit their health and the health of their children.

Women must have access to contraceptives, so that they do not become pregnant too early, too often or too late in life, and so that families can offer the best possible quality of life to their children. Fertility regulation is a preventive health measure with both a family and a social dimension – a way of planning one's own life, and a means of achieving equity between men and women. Men also must be required to accept their full responsibilities in both sexual life and the reproductive process.

No society treats its women on absolutely equal terms with its men; all too often the health and well-being of women are compromised by a combination of neglect and abuse. Poor female health results in high rates of maternal mortality; as well as being morally unacceptable, the death of a woman in childbirth must today be seen as a failure of society. No population programme should exist without a component of maternal health. All women should have access to reproductive health services, including family planning, obstetric care, and the prevention and management of sexually transmitted diseases, unsafe abortion and infertility. Their health should be a special matter of concern all through their life. No woman should become pregnant when she is not in good health; the consequences affect not only herself and the baby but also her other children and the whole family. No woman should have to suffer from the often disastrous consequences of uncontrolled fertility.

WHO's working definition

The following definition of reproductive health, approved last April by the WHO Global Policy Council, provides the basis for action in this field.

- "Within the framework of WHO's definition of health as a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity, reproductive health addresses the reproductive processes, functions and system at all stages of life."
- "Reproductive health implies that people are able to have a responsible, satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are the right of men and women to be informed of and to have access to safe, effective, affordable and acceptable methods of fertility regulation of their choice, and the right of access to appropriate health care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant."

Reproductive health must address, as its basic elements, sexual behaviour, family planning, maternal care and safe motherhood, abortion, reproductive tract infections (including sexually transmitted diseases and HIV/AIDS), and certain reproductive tract malignancies such as cervical cancer. ■

WHO in action

Ten crucial steps to child health

UNICEF and WHO have brought to the attention of all heads of government and heads of state the ten priority goals that are essential if the health and well-being of children all over the world are to improve. A joint letter signed by Mr James Grant, Executive Director of UNICEF, and Dr Hiroshi Nakajima, Director-General of WHO, called on the world's statesmen to apply their "personal leadership" to achieving these goals. They noted that, "along with intensified efforts to reduce malnutrition, to expand access to safe drinking water and sanitation, and to promote universal primary education," these ten steps would put each country on the right footing "to effectively pursue other socioeconomic development goals."

The Ten Priority Goals to be achieved by the end of 1995 are:

1. **Raise immunization coverage to at least 80%.**
2. **Eliminate neonatal tetanus.**
3. **Reduce measles deaths and cases.**
4. **Eradicate poliomyelitis in key areas.**
5. **Increase the use of oral rehydration therapy (ORT) to 80% of cases to help control diarrhoea.**
6. **Make maternity hospitals "baby-friendly" by supporting breast-feeding and end free and low-cost supply of breast-milk substitutes to health care systems as defined by the International Code.**

Dr Nakajima signs the joint WHO/UNICEF letter urging the world's leaders to make a personal commitment in favour of children

7. **Achieve universal iodination of salt.**
8. **Virtually eliminate vitamin-A deficiency.**
9. **Virtually eradicate guinea-worm disease.**
10. **Ratify the Convention on the Rights of the Child in every country.**

The letter from the two UN agency chiefs adds: "It is our conviction that the achievement of these goals is dependent not so much on additional financial resources, important as this may be, but even more on the political will, vision and commitment of leaders like yourself."

The World Summit for Children, held at the United Nations in New York in 1990, endorsed a set of ambitious goals for the survival, protection and development of children to be achieved by the year 2000. Since that time, some 100 countries, both developed and developing, have prepared National Programmes of Action to put into effect the goals and strategies of the World Summit. More than 150 countries around the world have ratified the Convention on the Rights of the Child.

But much else remains to be done, and the two Organizations consider that the attainment of the mid-decade goals outlined in their letter can serve as the foundation for achieving the goals and targets for the year 2000. ■

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In the next issue

Keeping people with chronic illness, and the elderly, in the familiar environment of their homes is probably less costly, and infinitely more satisfactory from the human point of view, than institutional care. The July–August issue of **World Health**, published on the occasion of the International Conference on Home Care to be held in Chicago (USA) in October, will describe different aspects of this important topic. ■

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